STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155149	B. WING		02/25/2011
NAME OF I	PROVIDER OR SUPPLIER	t		ADDRESS, CITY, STATE, ZIP CODE	
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		ARCOURT ROAD IAPOLIS, IN46260	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000	This visit was fo Complaints IN00 IN00085965. Complaint IN000 Federal/state def allegations are cir F309, and F333. Complaint IN000 Unsubstantiated, Survey dates: F6 2011 Facility number: Provider number AIM number: 10 Survey team: Chuck Stevenson Kimberly Perigo 2011) Census bed type: SNF: 10 SNF/NF: 64 Total: 74 Census payor type: Complaint IN000 Insubstantiated,	r the Investigation of 2085791 and 2085791 and 2085791 and 2085791 and 2085791 - Substantiated. Sciencies related to the sted at F157, F225, F226, 2085965 - 2000070 cm 21, 22, 23, 24, 25, 2000070 cm RN 200266190 an RN 20 RN (February 22, 23, 24, 25, 24, 25)	F0000	The creation and submission of thi plan of correction does not constitute an admission by thi provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requiests that the 2567 plan of correction be considered the letter of credib allegation and request a Desk Review on or after 3/20/11.	of s : n of
	Medicare: 16				
	Medicaid: 58				
	Total: 74				
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PVM011

Facility ID:

000070

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 02/25/2011	
HARCOL		RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT ROAD IAPOLIS, IN46260	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	O BE	(X5) COMPLETION DATE
TAG	Sample: 15 These deficiencie findings cited in 16.2.	es also reflect state accordance with 410 IAC //11 by Suzanne Williams, RN	TAG	DEFICIENCY	PRIAIE	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155149	B. WING			02/25/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARCOURT ROAD		
HARCOL	JRT TERRACE NUF	RSING AND REHABILITATION			APOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
F0157	Based on record	review and interview, the	F01	57	F157 Notification of Changes		03/20/2011
SS=D	facility failed to	ensure a resident's			is the practicew of this provide	r to	
00-0	_	otified of a significant			ensure that the attending		
		(the failure to give 4			physician is immediately inforn change of condition in a reside		
		kly doses of Avonex, a			physical, mental, or psychosoc		
		•			status deteriorate. What	Jai	
		n, given by injection for			corrective action will be		
	U 1	es of exacerbation of			accomplished for those reside	nts	
	_	s), for 1 of 3 residents in			found to have been affected by		
	a sample of 15 (F	Resident G) reviewed for			the deficient practice: * Resid		
	medication admi	nistration compliance.			G physician was otified of alleg		
					deficient practice. * Family was notified of alleged deficient	as	
	Findings Include	c			practice. * The medication wa	10	
					obtained and administered.Ho		
	A facility policy	titled "General			will you identify other residents		
					having the potential to be affect		
	Guidelines for A	C			by the same deficient practice		
		ed 7/26/06 received form			and what corrective action will		
		fursing (D.O.N.) on			taken: * Facility wide audit wa		
	2/23/2011 at 11:3	30 a.m. and indicated to			completed to identify others wi		
	be the facility's c	urrent medication			have the potential to be affext the same alleged deficient	БУ	
	administration po	olicy indicated:			practice. * No other residents		
	•	,			were identified.What measures	3	
	"Policy: Medicat	ions are administered as			will be put into place or what		
	prescribedin ac				systemic changes you will mal	ке	
	•				to ensure that the deficient		
		sing principles and			practice does not recur *		
	practices."				Notification of change of condi		
					in residents will be reviewed da Monday thru Friday except	ally	
	A facility policy	titled "Medication			weekends and holidays.		
	Discrepancy Rep	oort" dated 1/07 received			* Change of condition CQI will	be	
	form the Director	r of Nursing (D.O.N.) on			completed weekly x 4, monthly	/ X	
		30 a.m. and indicated to			2 and quarterly thereafter. *St		
		urrent medication			will be inserviced on change of	f	
		orting policy indicated:			condition on 3/17/11. How the		
	arscrepancy repo	nums poncy maleated.			corretive action will be monitor		
					to ensure the deficient practice	;	
			1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED	
		155149	B. WIN			02/25/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	L Company of the Comp			ARCOURT ROAD		
HARCOL	IRT TERRACE NUI	RSING AND REHABILITATION		1	IAPOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	5
	"Policy:An error shall be defined as any				will not recur: * Director of nursing or designee will monit	or	
	variation in admi	inistration of medication			results and makeappropriate	JI	
	from the physicia	ans (sic) orders			corrections. * Results will be		
					brought to the Quality Assurar	ice	
	Procedure: Notif	y the physician/alternate			meetings for continued		
		tor of Nursing and			monitoring.Compliance date:		
	consultant pharm	•			3/20/11		
	Consultant phani	14015					
	The record of Do	esident G was reviewed					
		1:45 p.m., and again on					
	2/25/2011 at 10:3	30 a.m.					
	Diagnoses includ	led, but were not limited					
	ı ~						
	1	osis, schizophrenia,					
		, hypothyroidism, and					
	constipation.						
	Δ physician's ord	der originally dated					
	1 * *	enewed on the January					
		·					
	I	11 Recapitulation of					
	1 -	rs indicated "Avonex					
	prefilled syr (syr	O /					
	(micrograms) Inj	ject IM (intramuscularly)					
	every week on T	hurs					
	(Thursday)Mul	Itiple Sclerosis."					
	Review of reside	ent G's Medication					
	Administration F	Records for January and					
		ndicated Resident G did					
	1 -	ex injections as ordered					
		03/2011, 2/10/2011, and					
	1	· · · · · · · · · · · · · · · · · · ·					
		ecord did not document					
	any notification	of the physician or					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			Ì	ILDING	NSTRUCTION	COMP 02/25/2	LETED
	PROVIDER OR SUPPLIER	IL STATE OF THE ST	B. WI	STREET A 8181 H	DDRESS, CITY, STATE, ZIP CODE ARCOURT ROAD APOLIS, IN46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	D.O.N. of the mi of these dates.	issed medications on any					
	p.m. the D.O.N. been notified of a by any staff men resident G had no ordered. She stat that."	iew on 2/22/2011 at 2:25 indicated she had not the missed medications of the received the Avonex as ed "There's no excuse for relates to complaint					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLE	
		155149	B. WIN	J		02/25/20	11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ARCOURT ROAD		
HARCOL	JRT TERRACE NUF	RSING AND REHABILITATION		INDIAN	APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG	F225: Investigate/Report		DATE
F0225		ew and record review, the	F02	25	AllegationsIt is the practice of		03/20/2011
SS=D	_	ensure a significant			provider to ensure that all alleg		
		(the failure to give 4			violations involving mistreatme		
		kly doses of Avonex, a			neglect or abuse icluding injuri	ies	
		n, given by injection for			of unknown sources and misappropriations of resident		
		s of exacerbation of			property by reported.What		
	•	s) was thoroughly			corrective action will be		
	_	reported to the State			accomplished for those reside		
		dance with State law for 1			found to have been affected by the alleged dificient practice:	y *	
		a sample of 15 reviewed			Investigation of alleged deficie	nt	
		and reporting unusual			practice with resident G was		
	occurrences. (Re	esident G)			completed. * Allegation was		
					reported in accordance with th state law. * Physician was	e	
	Findings include:	:			notified. How will you identify		
					other resdients having the		
		sident G was reviewed			potential to be affected by the		
		1:45 p.m., and again on			same alleged deficient practice		
	2/25/2011 at 10:3	30 a.m.			and what corrective action will taken: * Residents residing a		
					the facility have the potential to		
	Diagnoses includ	led, but were not limited			affected by the alleged deficie		
	to, multiple scler	osis, schizophrenia,			practice. * A facility wide aud		
	diabetes mellitus	, hypothyroidism, and			was completed to identify othe that may be affected. * No ot		
	constipation.				residents were identified. Wha		
					measures will be put into place		
	1 2	ler originally dated			what systemic changes you w		
	6/06/2000 and re	newed on the January			make to ensure that the allged		
	and February 201	11 Recapitulation of			deficient practice does not rec * Staff will be inserviced on	ui.	
	Physician's Order	rs indicated "Avonex			3/17/11 on abuse, residents		
	prefilled syr (syri	inge) 30 MCG			rights, and medication errors.	*	
	(micrograms) Inj	ect IM (intramuscularly)			Resident rights CQI will be		
	every week on Thurs (Thursday)Multiple Sclerosis."				completed by Social Service weekly x 4, monthly x 2 and		
					quaeterly thereafter. How the		
					corrective action will be monitor	ored	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155149	B. WIN			02/25/2	011
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	•	8181 H	ADDRESS, CITY, STATE, ZIP CODE IARCOURT ROAD IAPOLIS, IN46260	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΝΤΕ	(X5) COMPLETION DATE
	indicated: "Avonex-interfer reduce frequency relapsing-remitting Also inhibits pround A Health Care Plant recently updated re				to ensure the deficient practic will not recur 1.e. what qualit assurance program will be pure into place: * ED/DON or designee will monitor complet of CQI tools. * Result will be brought to the Quality Assurance tings for continued review.Compliance date: 3/2	y t ion ce	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011		
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT ROAD APOLIS, IN46260	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Avonex as ordere excuse for that."	ed. She stated "There's no				
	at 11:45 a.m., the there was no doc investigation into G not being adm no staff interview that no incident is completed. The A the incident had State Agency. The D.O.N. if this reported, and the it should have."	and D.O.N. on 02/25/2011 to D.O.N. indicated that the bumentation of any to the incident of Resident inistered her Avonex, that we were documented, and				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155149	B. WING			02/25/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			8181 H	ARCOURT ROAD		
		RSING AND REHABILITATION			IAPOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG	,		DATE
F0226		ew and record review, the	F02	26	F226: Develop/Implement Abuse/Neglect, ETC policylt is	s	03/20/2011
SS=D	<u>-</u>	ensure a significant			the practice of this provider to	5	
		(the failure to give 4			ensure that all alleged violation	ns	
		kly doses of Avonex, a			involving mistreatment, negled	t or	
	form of Interfero	n, given by injection for			abuse, including injuries of		
	reducing episode	s of exacerbation of			unknown sources and misappropriations of resident		
	multiple sclerosis	s) was thoroughly			property by reported. What		
	investigated and	reported to the State			corrective action will be		
	Agency in accord	dance with facility policy			accomplished for thoe residen		
	for 1 of 3 residen	its in a sample of 15			found to have been affected by		
		estigating and reporting			the alleged deficient practice:		
	unusual occurren				Investigation of alleged deficie practice with resident G was	nt	
					completed. * Allegation was		
	Findings Include				reported in accordance with th	е	
	i mamga merade	•			state law. * Physician was		
	1 A facility poli	ay titled "Papartable			notified.How will you identify o		
		cy titled "Reportable nces" revised 01/25/06			residents having the potential be affected by the same allege		
					deficient practice and what	s u	
		e Administrator on			corrective action will be taken:	*	
		p.m. and identified as a			Residents residing at the facili		
	current facility po	olicy indicated:			have the potential to be affected		
					by the alleged deficient practic	e.	
	_	ure that reportable			* A facility wide audit was completed to identify others th	at	
	occurrences are r	recorded and monitored			may be affected. What measur		
	to facilitate comp	oliance with state and			will be put into place or what		
	federal laws.				systemic changes you will mae		
					ensure that the alleged deficie		
	Policy: All unusu	al occurrences reported			practice does not recur: * Sta will be inserviced on 3/17/11 o		
	_	ertment of Health will be			abuse, resdients rights, and	11	
	•	cked or monitored to			meidication errors. * Residen	ts	
	insure residents a	are receiving appropriate			rights CQI will be completed by	y	
	care and services.				Social SErvice weekly x 4,		
		-			monthly x 2 and quarterly		
Procedure: Occurrences		rrences to be reported:			thereafter. How the corrective action will be monitored to ens	ure	
	1 1000ddie. Occu	reflect to be reported.			assor will be morniored to one		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPL	ETED
		155149	B. WIN			02/25/20	011
NAME OF F	DROLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			8181 H	ARCOURT ROAD		
		RSING AND REHABILITATION			APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		uired by law to report			the deficient practice will not recur i.e.what quality assurance		
		ices within 24 hours to	program will be put into place: *				
	the Long Term C	are Division."			ED/DON or designee will mon		
					completion of CQI tools. *Res	ult	
		titled "Reporting and			will be brought to the Quality		
		ty Incidents" revised			Assurance meetings for cotinu review.Compliance date: 3/20		
	01/07 received fr	om the Administrator on			10 vic vv. Compilarios date. 3/20	"	
	2/21/11 at 2:30 p	.m. and identified as a					
	current facility p	olicy indicated:					
	"Policy: The pur	pose of reporting facility					
	incidents in a pre	escribed format and					
	procedure is to a	ssist in the treatment and					
	l ⁻	residents by analyzing					
	incidents						
	Responsibility: A	Administrator, Director of					
	1 1	Nurse, Quality Assurance					
	•	Department Heads.					
		o op with the was.					
	Definitions: Incid	dent: An incident is an					
		onsistent with the routine					
		facility or the routine care					
	of a particular res	-					
	or a particular to	orderit.					
	Procedure: The C	Charge Nurse at the time					
		responsible to complete					
	the Incident Doc						
	_	ol and communicate to					
	_	The Charge Nurse will					
	notify the Director of						
	_	strator in a timely					
	mannerthe Dire	ector of Nursing or					

PRINTED: 03/22/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMPL 02/25/2	ETED
		100149	B. WI			02/25/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ARCOURT ROAD		
		RSING AND REHABILITATION		1	APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		e responsible to notify the	+	1110			Ditte
	appropriate State	_					
		ugoney					
	A facility policy	titled "Incident					
		and Investigation" dated					
	11/05 received fr	om the Administrator on					
	2/21/11 at 2:30 p	.m. and identified as a					
	current facility p						
		dents involving resident					
	care will be inves	stigated and documented					
		Occumentation and					
		l to enable the facility to					
		en to residentsan					
		occurrence which is not					
		he routine operation of					
	I -	e routine care of a					
	particular resider	nt					
	Procedure: Comp	oleting the Incident					
	Documentation a	and Investigation					
	Form:The char	ge Nurse at the time of					
		incident is responsible					
		n investigation of the					
		rrounding the incident,					
	1	the Director of Nursing					
		atorThe Charge Nurse					
		incident is responsible to					
	_	ident Documentation and					
		olThe Charge Nurse at					
		cident is responsible for					
	1	incident in the resident's					
	medical record	"					

000070

PRINTED: 03/22/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:				ULTIPLE CO LDING	NSTRUCTION	(X3) DATE S	ETED
		155149	B. WIN			02/25/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HARCOL	JRT TERRACE NUF	RSING AND REHABILITATION		1	ARCOURT ROAD APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	The record of Re	esident G was reviewed					
		1:45 p.m., and again on					
	2/25/2011 at 10:3	-					
	=/ =0 / = 0 1 1 10						
	Diagnoses includ	led, but were not limited					
	to, multiple scler	osis, schizophrenia,					
	diabetes mellitus	, hypothyroidism, and					
	constipation.						
		der originally dated					
		enewed on the January					
		11 Recapitulation of					
	prefilled syr (syr	rs indicated "Avonex					
		ject IM (intramuscularly)					
	every week on T						
	(Thursday)Mul						
	(11101300)	wipie sererosis.					
	The Nursing Spe	ectrum 2010 Handbook					
	indicated:						
	"Avonex-interfer	onIndication: To					
		of exacerbations in					
	1 0	ng multiple sclerosis.					
	Also inhibits pro	liferation of T-cells."					
	A II. dd C - Bi	lon Con Decident C					
		lan for Resident G, most					
	recently updated	7/15/2010, indicated:					
	"Related Diagnos	sis: Multiple Sclerosis					
	Problem Onset: (02/03/2009					

000070

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			COMPL		
111,1212111	or condition,	155149	A. BUILDING			02/25/2011	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	1			ARCOURT ROAD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		1	APOLIS, IN46260		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG	Goal: Resident w	<u> </u>	+	TAG	DIA TOLLANCI)		DATE
	complications in	rough next assessment					
	Approaches:Ao ordered"	dminister Avonex as					
	Administration F February 2011 in not receive Avon	ent G's Medication Records for January and adicated Resident G did nex injections as ordered 03/2011, 2/10/2011, and					
	2/17/2011. The record did not document any notification of the physician or D.O.N. of the missed medications on any of these dates.						
	p.m., the D.O.N. unaware resident	iew on 2/22/2011 at 2:25 indicated she was t G had not received the ed. She stated "There's no					
	at 10:30 a.m. found investigation into th Avonex doses, no co Documentation and	Investigation Form, and no esident had been assessed for					
	at 11:45 a.m., the	iew with the ad D.O.N. on 02/25/2011 e D.O.N. indicated that sumentation of any					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED B. WING 02/25/2011			LETED
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			STREET A 8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT ROAD IAPOLIS, IN46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	G not being adm no staff interview that no incident recompleted. The Athe incident had state Agency. The D.O.N. if this reported, and the it should have."	o the incident of Resident inistered her Avonex, that we were documented, and report had been Administrator indicated not been reported to the ne Administrator asked as should have been D.O.N. responded "Yes, tes to complaint IN00085791.				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155149	B. WING			02/25/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARCOURT ROAD		
HARCOURT TERRACE NURSING AND REHABILITATION		RSING AND REHABILITATION			IAPOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	_	DATE
F0309	Based on record	review and interview, the	F03	09	F309: Provide Care/Services	for	03/20/2011
SS=E	facility failed to	ensure a resident			Highest Well Beinglt is the		
00-L	<u>-</u>	eived necessary care to			practice of this provider the	_	
	, ,	the highest practicable			necessary care and services to attain or maintain the highest	0	
	physical well-bei	• •			practicable physical, mental, a	nd	
					psychosocial well being.What		
		eations as ordered by the			corrective action will be		
	physician (the fa	C			accomplished for those reside	nts	
		kly doses of Avonex, a			found to have been affected by	y	
	form of Interfero	n, given by injection for			the deficient practice: *		
	reducing episode	s of exacerbation of			Residents physician was notifi	ed	
	multiple sclerosis	s) for 1 of 3 residents in a			of alleged deficient practice. * An assessment of resident G	N36	
	sample of 15 rev	iewed for medication			completed on 2/25/11 to identi		
	administration co				any decline.How will you ident	-	
		,p			other residents having the		
	Eindings Include				potential to be affected by the		
	Findings Include				same deficient practice and wh		
					corrective action will be taken:		
	A facility policy				* Residents residing in facility		
	Guidelines for A	dministrating			have the ability to be affected. A facility wide audit was		
	Medication" date	ed 7/26/06 received form			completed to identify any other		
	the Director of N	fursing (D.O.N.) on			that may be affected by same		
	2/23/2011 at 11:3	30 a.m. and indicated to			alleged deficient practice, * N	No	
		urrent medication			other residents were		
	administration po				identified.What measures will l	be	
	administration po	mey marcated.			put into place or what systemic		
	UD 1: 34 1: 4				changes you will make to ensu		
"Policy: Medications are administered as				that the deficient practice does not recur: * Staff will be	5		
	prescribedin ac				inserviced on 3/17/11 on policy	,	
		sing principles and			and procedure as related to	,	
	practices."				services needed by residents.	*	
					New admission and existing		
	The record of Re	sident G was reviewed			residents will be monitored for		
	on 2/22/2011 at 1	1:45 p.m., and again on			needs and services upon		
	2/25/2011 at 10:3	1			admission, quarterly and as		
	_,,,	· · · · · · · · · · · · · · · · · · ·			indicated by change of conditions. How the corrective		
					Conditions. Now the Confective		
			1		I		

l		X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCT		NSTRUCTION		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		155149	B. WIN	iG		02/25/2	011
NAME OF F	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
THIND OF THE VIDER OR SOFTELER					ARCOURT ROAD		
HARCOURT TERRACE NURSING AND REHABILITATION			INDIAN	APOLIS, IN46260			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 ~	ded, but were not limited			action will be monitor to ensu		
	1 * *	rosis, schizophrenia,	the deficient practice does not recir: * DON/ADON or designe		I		
		s, hypothyroidism, and			will monitor for completion. *		
	constipation.				Results will be brought to the		
					Quality Assurance meetings for	or	
	1	der originally dated			reviiew. Compliance date: 3/20/11		
		enewed on the January			0,20,11		
	and February 20	11 Recapitulation of					
	Physician's Orde	ers indicated "Avonex					
	prefilled syr (syr	ringe) 30 MCG					
	(micrograms) In	ject IM (intramuscularly)					
	every week on T	hurs					
	(Thursday)Mu	ltiple Sclerosis."					
	The Nursing Spe	ectrum 2010 Handbook					
	indicated:						
	"Avonex-interfer	ronIndication: To					
	reduce frequency	y of exacerbations in					
		ng multiple sclerosis.					
	1 ^ ~	oliferation of T-cells."					
	A Health Care P	lan for Resident G, most					
		7/15/2010, indicated:					
	J	,					
	"Related Diagno	sis: Multiple Sclerosis					
		· F					
Problem Onset: 02/03/2009							
	Goal: Resident v	vill be free of					
		rough next assessment					
		20.0011 110/11 4000001110111					
	Approaches: A	dminister Avonex as					
	ordered"						
	ordered						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155149	B. WING		02/25/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
HARCOURT TERRACE NURSING AND REHABILITATION			INDIAN	IAPOLIS, IN46260	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE
	Review of reside Administration R February 2011 in not receive Avon on 1/27/2011, 2/0 2/17/2011. The rany notification of D.O.N. of the mi of these dates. During an intervipum, the D.O.N. unaware resident Avonex as ordere excuse for that."	nt G's Medication Records for January and adicated Resident G did ex injections as ordered 03/2011, 2/10/2011, and ecord did not document of the physician or ssed medications on any see on 2/22/2011 at 2:25 indicated she was a G had not received the ed. She stated "There's no relates to complaint			

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUME		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155149	B. WING			02/25/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARCOURT ROAD		
HARCOURT TERRACE NURSING AND REHABILITATION		RSING AND REHABILITATION			IAPOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0333	Based on record	review and interview, the	F03	33	F333: Residents Free of		03/20/2011
SS=E	facility failed to	ensure a resident			Significant Medication Errors:	I IS	
	(Resident G) was	s protected from a			the practice of this provider to ensure that residents are free	of	
		eation error (the failure to			any significant medication erro		
	_	ve weekly doses of			What corrective action will be		
	_	of Interferon, given by			accomplished for those reside	nts	
	injection for redu				found to have been affectied b	y	
	_	0 1			the deficient practice: *		
		nultiple sclerosis) as			Resident's physician was notif		
		nysician for 1 of 3			of alleged deficient practice. * The medication was obtained		
	residents in a san	nple of 15 reviewed for			administered. * Resident was		
	medication admir	nistration compliance.			assessed for decline in functio		
					How will you idenfity other		
	Findings Include	:			residents having the potential	to	
	C				be affected by the same defici	ent	
	A facility policy	titled "General			practice and what corrective		
		dministration" dated			action will be taken: *Residen		
					residing in facility have the abi	-	
		form the Director of			to be affected. * A facility wide audit was completed to identify		
	<u> </u>) on 2/23/2011 at 11:30			any others that may be affected		
		ed to be the facility's			same alleged deficient practice		
	medication admir	nistration policy			* No other residents were		
	indicated:				identified, What measures will		
					put into place or what systemic		
	"Policy: Medicat	ions are administered as			changes you will make to ensu		
	prescribedin ac				that the deficient practice does not recur: * Staff were inservi		
	•	sing principles and			on 2/22/11 on proper medication		
		sing principles and			pass and procedure for missin		
	practices."				medication. * New admission		
	m1 1 0 5				and existing residents		
		sident G was reviewed			medications will be monitored	for	
		1:45 p.m., and again on			correct medication, dose, and		
	2/25/2011 at 10:3	30 a.m.			schedule. * Medication		
					administration record and Treatment administration record	-d	
	Diagnoses includ	led, but were not limited			will be reviewed 3 x weekly by	-	
	_	osis, schizophrenia,			unit managers. * Medication		
	, 1	, ,					

000070

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED		
		155149	B. WIN	B. WING 02/25/2011				
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	E		
TWINE OF T	ROVIDER OR SOLITEIER	•		1	ARCOURT ROAD			
HARCOL	JRT TERRACE NUF	RSING AND REHABILITATION	1	INDIAN	APOLIS, IN46260			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE ROPRIATE		
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE	
		, hypothyroidism, and			Error CQI will be comple DON/designee weely x 4	-	•	
	constipation.				x 2 and quarterly thereaf			
					the corrective action will			
	A physician's ord	ler originally dated			monitored to ensure the	deficie	ent	
	6/06/2000 and re	newed on the January			practice will not recir: *			
	and February 201	11 Recapitulation of			DON/ADON or designee monitor for completion.		ult	
	Physician's Order	rs indicated "Avonex			will be brought to the Qu		ait.	
	prefilled syr (syri	inge) 30 MCG			Assurance meetings for			
	(micrograms) Inj	ect IM (intramuscularly)			Compliance date: 3/20/	11		
	every week on T	hurs						
	(Thursday)Mul	Itiple Sclerosis."						
		•						
	The Nursing Spe	ectrum 2010 Handbook						
	indicated:							
		onIndication: To						
		of exacerbations in						
		ng multiple sclerosis.						
		liferation of T-cells."						
	Also illiloits pro	incration of 1-cens.						
	Review of reside	ent G's Medication						
	Administration R	Records for January and						
		ndicated Resident G did						
	_	ex injections as ordered						
		03/2011, 2/10/2011, and						
		ecord did not document						
		of the physician or						
	_	ssed medications on any						
	of these dates.	incurrentials on any						
	or mese dates.							
	During an intervi	iew on 2/22/2011 at 2:25						
	_	indicated she was						
	•	G had not received the						
		ed. She stated "There's no						
	Avonex as ordere	a. one stated There's 110						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	<u> </u> PVM011	Facility I	ID: 000070 If continu	uation sh	eet Page 19 of 20	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT ROAD IAPOLIS, IN46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	excuse for that."	relates to complaint	TAG	DEFICIENCY)	DATE